STG Resilience Papers

Macro-health system governance and the UHC agenda: Key learnings from the COVID-19 pandemic

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Summary:

- Prior to the Covid-pandemic, the 'Political Declaration of the High-Level Meeting on Universal Health Coverage' signalled a high point for an approach to global health focussed on health systems.
- The Covid pandemic has served to highlight the critical importance of the fundamental goals of Universal Health Coverage ie broad and equitable access to services and essential technologies; multi-stakeholder participation in decision making; increased funding; and, protecting citizens against debilitating health care costs.
- The Covid pandemic has also demonstrated the need to delve deeper into the organisation and administration of health systems as the key factor in achieving universal health coverage and effective pandemic control.
- Four elements of health system governance have been exposed as key to maintaining resilient, adaptable, strong and equitable health systems and are manifest in how the relationships within health systems are organised, legitimised and maintained. First, relationships between levels and types of health services; second, relationships between levels of government and health administration; third, relationships between technical experts and decision makers; and fourth, relationships between public and private actors in health.
- Global health policy, the Universal Health Coverage paradigm and the drive to improve health will be strengthened by increasing attention to these factors and the empirical evidence base for improved health governance and administration.

1. Introduction

Immediately prior to the emergence of SARV-COV-2 and the ensuing global Covid-19 pandemic; global health policy had experienced a peak in political attention for Universal Health Coverage (UHC) as a key paradigm to strengthen health systems and achieve global health. As a set of health policy goals, Universal Health Coverage emphasizes the responsibility of governments to enable broad equitable access to quality health services and strengthen the health system pillars that are required to maintain them. The [2019 United Nations General Assembly Political Declaration of the High-Level Meeting on Universal Health Coverage](#) was passed following months of debate and negotiation in October 2019, just weeks before the [first known cases of SARS-COV-2](#) emerged in Wuhan, China.

The Covid-19 pandemic has arguably added further potency to the call for attention on strengthening health systems and achieving UHC. The worst effects of the pandemic arose in situations where health systems became overwhelmed; as numbers of severe cases exceeded the capacity of available health services. This was seen at different times in both high, middle and low income countries around the world including [Italy](#), [Brazil](#), the [United States of America](#) and [India](#). The pandemic has also highlighted the importance of strong health systems that can cope with unexpected and unknown external shocks; overlapping with goals of the [Health Security](#) paradigm.

Taken as a learning opportunity, Covid-19 has served to both highlight the relevance of the UHC agenda; but also test its veracity and the depth of its evidence base. *What has emerged from the experience of the pandemic about the essential pillars of strong resilient health systems?*

In this contribution, four key elements of health system governance are highlighted as key defining characteristics of resilience in the pandemic that present opportunities for improvement. First, relationships between levels and types of health services; second, relationships between levels of government, specifically centralised and local health authorities; third, relationships between technical experts and health system decision makers; and fourth relationships between public and private actors in health.

2. Background

Global health policy can be seen as both a technical as well as a political field. The technical involves identifying burden of disease, the determinants of that burden and progressing through processes of policy transfer and policy learning to develop the tools to best prevent or alleviate the targeted burden. The political involves the negotiation priorities, aspirational targets and overarching approaches to achieving global health equity and improvement. These twin technical and political processes, subject

to external shocks, policy entrepreneurship and the politics of power; have meant that different conceptual paradigms of global health policy have waxed and waned over time.

This global health narrative has origins that precede the era of the United Nations institutions and the founding of the World Health Organisation (WHO) in 1948; but is dominated by debates and approaches that have surrounded the Organisation ever since. The middle of the 20th century saw a focus on identifying and combating specific diseases – most notably small pox and polio – now referred to as a 'vertical' approach to global health. The late 1970s saw a shift in discourse and the emergence of community based, 'horizontal' approaches, embodied in the mantra of "Health for All", Primary Health Care and the Declaration of Alma Ata. This was quickly supplanted by intervention focused approaches in the 1980s. A data-measurement-investment based paradigm came to dominate global health in the 1990s, spearheaded by the entrance of the World Bank as a major player. This was inevitably followed by a renewed period of disease and technology-oriented; fund transfer based global health (embodied in models of public-private partnerships such as the Global Fund to Fight Aids, Tuberculosis and Malaria, and the Global Alliance for Vaccines and Immunisation) of the turn of the century. The debate between the 'vertical' and 'horizontal' approaches continued, as these partnerships came under pressure to ensure their programs were sustainable; requiring attention to whole-of-system strengthening.

Systems based approaches bounced back into focus with the ensuing Health Systems Strengthening (HSS) movement, as well as further developments under the guise of OneHealth and Health Security, including the revision of the World Health Organisation's International Health Regulations in 2005. The Sustainable Development Goals launched in 2015 were broadly more systems-based than its predecessor, the Millennium Development Goals.

2.1 UHC as a global health policy paradigm

Universal Health Coverage gained momentum as a unifying, broad and systems-based approach in the 2010s, although its origins can be traced back to movements a century earlier. Despite what may be suggested by its name, UHC is not just centred around the expansion of health insurance. In the 2019 UN Political Declaration of the High-Level Meeting on Universal Health Coverage the focus was placed on: *"the need for health systems that are strong, resilient, functional, well-governed, responsive, accountable, integrated, community-based, people-centred and capable of quality service delivery, supported by a competent health workforce, adequate health infrastructure, enabling legislative and regulatory frameworks as well as sufficient and sustainable funding".* The document drew out a comprehensive and wide ranging list of key principles that should underpin achieving UHC: with a

particular focus on service accessibility; research, development and equitable distribution of essential medicines and technologies; increases in overall health funding; protection from financial burden; the rights of vulnerable groups; growth of the health workforce and its capabilities and health system governance.

2.2 Linking UHC to health system resilience

Despite this comprehensive list of key principles, a 2020 survey of key stakeholders in countries party to the declaration undertaken by UHC2020 – the organisation tasked with overseeing progress towards the goals stated in the declaration – found that many states were "unclear about what constitutes a UHC commitment" and what commitments governments are making to achieve it. UHC has achieved success as a movement and conceptual framework, but the UN declaration is best seen as a launching pad for the next stage in its development – a stage which will require building a strong evidence base for the operationalisation of UHC's key principles. The WHO health system building blocks still serve as a fundamental framework for much of the technical guidance for strengthening health systems, and one of those building blocks, "Governance and Leadership" is frequently cited as a key pillar of strong health systems – although it has proven difficult to define and even harder to measure. In a recent focused edition of BMJ Global Health, Bruno Messen found that while the literature on health system governance is growing, the empirical agenda is progressing only slowly.

No two health systems are the same, but Covid-19 was a uniquely common challenge that all health systems now face. Each health system has been a case study in health system resilience and the comparative combination of those cases has served to both highlight the relevance of health system governance and provide new inputs to the empirical evidence base.

3.   Health system governance – the glue that holds health systems together

Health system governance can be defined as the structures and institutions that determine the roles and responsibilities of, and relationships between, various health system actors in taking and enacting policy decisions. Governance has been an under researched areas of health; but UHC developed a pathway to acknowledging its importance. Experiences around the world as health systems were faced with the Covid-19 pandemic brought to light four key aspects of health system governance that have proven key to resilience and performance but have until now rarely been the focus of global health policy.

3.1 Organising relationships between public health, primary, secondary, and tertiary health services.

During the covid pandemic, health systems needed to monitor outbreaks and provide new services, in rapid time, on a large scale. The ability of health systems to surge in capacity and deploy technologies and workforce proved critical. The organisation of health services throughout health systems determined this capacity; in particular the extent to which access to covid related services was eased (single point of contact and free of up-front costs), trained workforce (clinical and administrative) was able to be redeployed, and diagnostic and treatment services were able to be coordinated.

Key factors included where in the system key functions of public health were located (who undertook contact tracing; who held responsibility for communicating public health messaging; how quickly could these functions be mobilised); how pathology was integrated into disease surveillance and reporting systems (including data transfer); and the how the place of primary care physicians as system entry points was managed. Most countries struggled to organize contact tracing efforts due to a mismatch between the workforce, resources and skills required to perform this task; and the administrative location of public health units in governments systems (e.g. as a health service vs a local government unit). The role of primary care physicians also proved a potential derailer in many health systems, as primary care is frequently provided by independently operating practitioners that link with other services through systems of arms-length referral. The ability to mobilise this independent (often private) workforce is highly dependent on how relationships to the broader health system are organised. In some countries community based primary health services were de facto bypassed in favour of hospital-based covid services; as these maintained a critical mass of funding and administrative capacity that allowed for rapid redeployment of workforce; use of new technologies and access to infrastructure and physical space. In other health systems independently operating primary care physicians played a central role where relationships with public health and tertiary services were managed through meso-level (regional) organizational units and established systems of patient information flows.

3.2 Organising relationships between central and local administrative levels.

In the early stages of the pandemic, some federal systems appeared to work together in new innovative ways. Key case studies in the responses of centralized and devolved government systems to the pandemic have consistently found political and public discourse favoured strong centralized action and decision making in the first half of 2020. In Australia, a restructured decision making forum comprising of state and federal leaders (named the National Cabinet) was successful in determining common public health policy; including agreement on border closures. In Italy the use of legal provisions to declare a state of emergency at the national level was supported; although responses in the first wave

were regional and successes and failures closely correlated to regional differences in service provision. In Germany the conference of state leaders under leadership of the federal government set national health policy in the early months and was able to devise a system definition of threshold criteria by which local public health measures would come into force. The urgency of cooperation meant that federal and multi-level government systems, were paralleling centralized systems such as New Zealand and Singapore in terms of "top-down impetus". However, as the pandemic progressed the difficulties of compromise in devolved systems re-emerged with vengeance. All three countries mentioned above, and other federal systems such as Switzerland, Malaysia, and the United States, struggled to implement cohesive national action once the pandemic moved into a management phase with differential effects across regions within countries. Rivalries ensued between devolved administrative levels, particularly those governed by rival political parties, and much needed cooperation during critical times slowed. In extreme cases this blocked the transfer of essential equipment and workforce. Centralized systems on the other also faced difficulties establishing and implementing easily accessible test regimes and contact-tracing – which, as mention above – function best with localized coordination across health service provider types. The OECD found that a comparison of federalized and non-federalism health systems in the pandemic did not advantage one or the other on the whole; but did highlight the importance of clear roles, responsibilities and capabilities and importantly rules of deliberation, compromise and decision-making between levels of government and health administration.

3.3 **Organising relationships between evidence production, public health expertise, technical advisory and decision-makers**

All national governments rely on systems of political and policy advisory and expert input. The Covid-19 pandemic put rapid evidence production, appraisal and technical policy advice into the public spotlight as rarely seen before. Decision makers relied on evidence synthesis and expert advice to underpin policy decisions, ranging from predictive modelling of case burden trajectories to the effectiveness of interventions such as wearing face masks, curfews, border closures and vaccine allocations. Two main factors determined the strength of health systems to devise and use public health evidence and expertise.

First, strong health systems held the institutional infrastructure required for gathering evidence, its synthesis and interpretation into technical advice. Systems of public health surveillance needed to be time efficient and accurate; predictive models failed if disease reporting was slow or incomplete. This required efficient data transfer from pathology laboratories to local and ultimately central reporting

units; and established institutions for the analysis and communication of the meaning of this data. This function was dispersed in various combinations in different countries between established centers for disease surveillance and public health (e.g. Robert Koch Institute in Germany, Centres for Disease Control and Prevention in the United States); as well as committees that further interpret public health evidence into technical policy advice – some of which are long standing (e.g. Scientific Advisory Group for Emergencies (SAGE) UK; Leopoldina institute in Germany) and others which were formed ad hoc in response to the pandemic (e.g. National COVID-19 Health and Research Advisory Committee in Australia; the SARS-CoV-2 Genetics Consortium (INSACOG) in India and the Comitato Tecnico Scientifico in Italy). These agencies had to digest an unprecedented volume of scientific evidence, much needing action before peer review, on the aetiology, prevention and treatment of SARS-COV-2. The second key factor required to maintain an effective evidence-based response is sound relationships between these institutions, technical experts and decision makers; in particular leadership in government. These relationships require a particularly high level of maturity to steer the course during high-stakes decisions; especially as there was frequently fierce debate and even conflicting technical advice from experts where evidence was still emerging or equivocal. Many countries struggled with the need to be able to accept the nature such debate, respect the independence of technical institutions but also be willing to fully deliberate and take decisions based on technical advice. The Covid pandemic has exposed unprecedented successes in building better relationships between evidence production, public health expertise, technical advisory and decision-makers, as well as spectacular failures; for example in the United Kingdom, India and the United States where political leaders often contradicted or appeared to influence technical advice, and at times even maintained hostile relationships to advisors.

3.4 Organising relationships between the public and the private in health systems

Most health systems are comprised of a mix of public and private actors; from the providers of health services to health insurance; from the IT platforms that underpin medical records to the research, development and application of diagnostics, therapeutics and vaccines. Transcending ongoing debates around the dichotomies of interests, the pandemic has demonstrated the need to optimize the relationships between the public and private actors that now underpin the fundamental functioning of health systems.

These relationships must be organised to enable health systems that progress towards health equity and improvement; and Covid-19 has demonstrated the extent to which poor governance of these relationships have severe consequences during times of crisis. For example, regions that experienced

acute Covid-19 outbreaks required surge capacity in often unprofitable preventative, critical and intensive care services. Health systems, became overwhelmed where drivers of health system funding had [depleted these services](#) and isolated both public and private sectors from a whole-of-system crisis response, as was seen in both parts of [Italy](#) and in [India](#) during heights of their outbreaks.

The pursuit of suitable vaccines to fight the Covid-19 pandemic also exemplified the opportunities and challenges of optimizing relationships between public and private actors for health. The complex patterns of revenue raising, licensing, and purchasing have highlighted the truly incremental and global nature of medical research, while the ongoing challenges of manufacturing, procurement and distribution demonstrate the co-dependence of public and private sectors. Public-private inputs were initially successful in promoting rapid research into vaccines, with developers raising funds through both free market (e.g. [stock listings; bank loans](#)) as well as public means (e.g. [development bank loans](#) and [research grants](#)). This public-private mix has proven more challenging when it comes to vaccine production. Countries with established vaccine industries tended to be quicker in building out manufacturing capacity; for example by [purchasing smaller manufacturing sites](#), and entering arrangements for local production of vaccines under licensing arrangements, although shoring up [global supply chains](#) remains a challenge. Meanwhile, countries with established bulk-purchasing and systems fared well in [negotiating contracts for vaccines](#) in the development phase within a fiercely competitive global marketplace. International instruments such as the [Covax facility](#) sought to counteract an ensuing and ongoing global inequity in vaccine access by pooling public funds for vaccine procurement; while development banks have also [issued loans](#) to enable vaccine purchases and expand national delivery systems. Those delivery systems in turn have [additional layers of complexity](#), relying heavily on the ability of governments to contract services to both public and private sectors; from cold-chain transport, storage, record keeping, infrastructure for vaccination centres and ultimately a vaccinating workforce.

4. Conclusions

Four key sets of relationships, as key facets of health system governance, proved key to resilience in the pandemic and require ongoing attention. First, relationships between levels and types health services and how these are organised within government and administrative systems have been key to coping with health system demand. Second, relationships between central and local administrative levels have been a determining factor in enabling well-coordinated responses to health system challenges, particularly as the pandemic moved into management phases with more localized outbreaks. Third, relationships between evidence production, public health expertise and decision-

makers have required a high level of maturity to both understand the nature of evidence production as well as enable rational deliberation of technical policy advice. Finally, relationships between the public and private actors now underpin the fundamental functioning of health systems in almost all facets from research, health technologies, systems and services. Optimising these relationships is essential to ensure health systems that progress towards health equity and improvement.

The Covid-19 pandemic has served to highlight the importance of whole-of-systems approaches to global health and improving health system governance in particular. Framing health governance as the organisation of relationships between systems parts helps guide the construction of an empirical basis for health system improvement – and ultimately the further development of the Universal Health Coverage agenda.